Third Quarter 2023 Update on Health Care Trends

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August 2023

The top-line trends in 3Q 2023 differ little from those articulated in the 2Q trends memo back in May, but the underlying *root causes* powering these trends are becoming more salient, and their impact more heightened. To be fair, the most recently reported data have as their comparative performance a time in 2022 during which COVID-19 was much more prominent. We'll need to get closer to the 4Q of 2023 before we anniversary the direct impact of the pandemic, and better understand the post-pandemic performance profiles.

For health service providers, volume increases continue to be robust and continue to favor outpatient over inpatient, while contract labor expenses decrease as the labor force dynamics stabilize. The full expected margin lift from such volume increases is not yet completely apparent, however, and much of this can be attributed to significant disruption in the hospital-based physician sector (think Radiology, Anesthesiology, Pathology, and Emergency Medicine). The growing prominence of government reimbursed patients, the dramatic shift of orthopedic procedures from inpatient to outpatient, as well as elevated core labor costs (as opposed to contract labor costs) are also dampening the positive impact of robust volume growth.

For health insurers, the most significant developments remain in the regulatory and legislative arenas. Changes to the Medicare Advantage Risk Adjustment models are the most concerning development followed by increased legislative and judicial scrutiny into insurers' PBM

economics. As well, Blue Shield of CA just announced it is rejecting its more traditional PBM relationship with CVS/Caremark and assembling a number of partners including Amazon and Mark Cuban's pharmacy group thereby permitting it to operate without such support. We'll need to watch this one carefully, but it could represent the start of a commercial threat to the traditional PBMs beyond the regulatory and legislative threats.

Health service utilization is up, but most insurers are confident they will continue to "price ahead of trend" in terms of premium increases. Additionally, the insurers are starting to experience a nice cost-reduction tailwind from the introduction of many new biosimilar drugs. The bigger issue for several large insurers remains the underlying challenge of trying to align their insured membership with their captive integrated care delivery platforms focused on primary care, home care, and pharmacy. This challenge is proving more difficult than anticipated for at least a couple of large insurers (and Walgreens), forcing them to lower or withdraw earnings guidance.

I will introduce one new trend this quarter, and it's based on what's happening at the DOJ/FTC. Its latest proposed Merger Guidelines were issued on July 19th, and a close read suggests that the government now believes virtually any merger, vertical or horizontal, in-market or across markets, in any sector, is not good for the consumer. For many of us, this does not align with the realities of the health care sector.

Here we elaborate on each of these trends:

Market and Competitive Dynamic #1- Provider volume growth continues to be robust, yet related profitability still lags.

There is no question that patients are once again seeking elective procedures as both concern over COVID recedes and providers address

labor-related capacity constraints. For the large hospital companies, non-COVID related activity is up 5-10% over 2022 on an adjusted-admissions basis. The large clinical laboratories are experiencing similar levels of growth. For hospitals, outpatient orthopedic procedures seem to be in the forefront of this growth, followed by outpatient cardiac, GI, and cataract procedures. Inpatient activity is also up 2-4%, on balance. Behavioral health activity continues to soar. Teledoc reports behavioral health activity is up 18%. Dental visits for Medicare Advantage beneficiaries are way up too. Nearly all large insurers confirm the increases in patient activity reported by providers and suggest that most of it is occurring in their Medicare Advantage segments. How much of this is "deferred care" from COVID is hard to estimate, but several insurers reported that the May-June spike in patient activity actually started to recede in July.

Last quarter, we discussed why all this patient volume was not translating into significantly improved provider economics, given the high fixed-cost structure of provider facilities. While some factors have changed, others have become more prominent:

- There is still a residual runoff of COVID-related grant and supplemental reimbursement increases. For instance, THC's COVID-related grant revenue dropped from $94 million to $8 million Y-O-Y this past quarter
- Medicare IPPS and commercial reimbursement increases remain below the rate of inflation, and the final IPPS rule for 2024 at ~1.2% will continue to remain well below medical inflation Commercial reimbursement increases are coming in at mid-single digits, but commercial patients now represent less than 1/3 of some hospital companies' total patient volume (e.g., 70% of HCA's patients are now Medicare, Medicaid, or uninsured)
- Surgeries, particularly orthopedic-related ones, continue to migrate from inpatient to outpatient with the concurrent

reduction in revenue per case. United Healthcare reports that the reimbursement for a surgery performed in an outpatient setting is only 50% of the reimbursement for the same surgery as an inpatient, on average

- The combination of the two factors immediately above are leading to less than robust increases in net revenue per adjusted admissions (HCA=2.4%, CYH= -0.8%, UHS= 1.3%, THC better at 3-4%)
- While *contract* labor costs are down significantly, *core* labor wage rates continue to increase and the latter is offsetting much of the former. As a percent of revenue, SWB are actually *less than* they were in 2019 for HCA and THC, yet their Y-O-Y labor costs after consideration of contract labor declines are up 7.1% and 7.4%, respectively. At UHS, the increase was 9.0%. While some of these increases can certainly be attributed to increased volume, the providers are clearly dealing with significant inflationary labor cost increases
- Medical specialty fees charged to hospitals (e.g., Anesthesia, Radiology, Pathology, Emergency Medicine) continue to increase substantially. These are purportedly due to the No Surprises Act, which has impaired the ability of these physician groups to generate margin by billing insurers at patients for out of network rates. Usually categorized in the "Other Expenses" line item, physician fee increases are very likely contributing significantly to a 9.0% increase in "other expenses" at HCA and 11.8% at THC (there are many other cost categories in this expense line item, so these increases should not be attributed solely to physician fees). The financial collapse of American Physician Partners (APP) on July 31st led CYH to hire, or contract with, 500 of APP's physicians literally overnight. HCA launched a new physician management company called Valesco to deal with this issue

As large hospital providers go, THC may presently represent the most compelling strategy for dealing with all these forces. Simply stated, it's three-fold: elevate case mix index to increase inpatient revenue per case *beyond* third-party reimbursement increases, apply advanced analytic techniques to optimize labor staffing and productivity, and deploy capital into the fastest growing, less capital-intensive, higher margin adjacent parts of the sector (i.e., ASCs and revenue cycle management). ASCs now represent less than 20% of THC's revenue, but 40% of its total EBITDA. These ASCs generated an EBITDA margin of 39%. Confier (its RCM business) is 6% of revenue, but 10% of EBITDA. Conifer generated an EBITDA margin of 26%. Both of these segments are significantly more profitable and less capital-intensive than the hospital business.

Implications: Health system executives should not expect full margin recovery to attend post-COVID patient activity recovery in their hospital segments. Full margin recovery in the context of volume shifts toward much lower-reimbursed government insured patients, combined with sustainably elevated core labor expenses and a growing preference for outpatient over inpatient surgeries will all require real *annual* productivity gains or 2-3% for the foreseeable future. Diversification of revenue sources into higher-margin, higher-growth, lower capital-intensive adjacent businesses also looks increasingly as an imperative

Market and Competitive Dynamic #2- Strong performance for health insurers, but growing regulatory and business model challenges.

After unanimously elevating guidance earlier this year, all six major insurers (UNH, ELV, CVS, CNC, HUM, CI) either elevated guidance *again* or reaffirmed earlier increases, yet all of their stock values have decreased YTD in an otherwise bullish equity market.

As we described last quarter, there are some longer-term headwinds that may be contributing to this including 1) stricter criteria for Medicare Advantage STARs and risk adjustment coming out of CMS, 2) Medicaid redeterminations and their potential for a net *decrease* in insured lives, 3) FTC and legislative challenges to PBM economics, and 4) the likely expiration of supplemental ACA subsidies after 2025.

This quarter, the impact of CMS regulatory changes was in focus with several insurers expressing more concern about risk model changes than spikes in utilization among seniors. In the context of risk model changes and a 2024 rate notice that will effectively *decrease* the MA premium benchmarks, several insurers signaled they would invest in retaining or expanding market share during the upcoming AEP, including CNC's announcement of a $200 million Medicare Advantage "premium deficit reserve" (i.e., investment) for 2024. Humana indicated it will double-down on zero premium products. Competitive intensity for MA members appears to be increasing.

Separately, nearly all insurers noted significant increases in demand for behavioral health services and the growing recognition in the value of "whole person" care. While some insurers are intending to build chronic disease management platforms, ELV seems most focused on building a "whole person" care platform combining physical, social, and mental health services.

The increasingly prevalent introduction of biosimilar drugs noted several quarters ago is becoming more pronounced in this most recent quarter and has begun to represent a nice tailwind for insurers, employers, and consumers. For instance, CVS/AET reported that an earlier experience in introducing a biosimilar-like product to replace Lantus (used to help control diabetes) led to a 97% rate of patient conversion and a 21% reduction in costs for its customers.

Business model challenges for Insurers. Insurers have been diversifying for several years now, and this trend accelerated during the years 2020-2022. As we mentioned previously, many insurers have essentially become "bi-lateral, open integrated delivery networks. Specifically, as insurers, they contract with their owned providers as well as non-owned providers. And their owned providers have taken by necessity a "payer-agnostic" stance meaning they contract with many different insurers. There are three factors overall contributing to these insurer-led diversification trends:

- Insurers having P/E ratios in the 15-20 range have growth rates imputed in their stock prices that cannot reasonably be fulfilled by growth their core health insurance businesses alone. Thus, provider services, value-based care wrap around capabilities/analytics, and PBM-related adjacencies are all natural extensions of their businesses. Insurers also have the latitude to focus on very high growth areas such as ambulatory surgery centers, specialty pharma, and home health in attractive geographies as they diversify
- Owning providers and PBMs permits insurers to "park margin" in those parts of their organizations not regulated by minimum MLR regulations. PBM rebates are a great example of this. The customer gets charged a cost *before* rebate and this cost goes into the minimum MLR calculation, yet the PBM pockets at least a portion of the rebate as a contribution to profit after the fact. This rebate, which effectively represents a decrease in MLR is not entered back into the MLR calculation
- Finally, the belief that creating integrated care delivery platforms comprising primary care, home care, and pharmacy will materially lower medical expenses and improve outcomes for their own insured members. There is growing evidence of this impact in terms of reduced inpatient admissions, fewer emergency room visits, and greater adherence to drug regimens. The key challenge,

however, is aligning these platforms with one's insured member base, which includes scaling these models nationally. This is the challenge that seems to be increasingly confounding to insurers after having spent tens of billions of dollars on build-outs and/or acquisitions. Here are some facts:

- Fewer than 5% of HUM's MA members utilize its owned primary care clinics. Moreover, HUM added ~825,000 new MA members this year, yet grew its owned clinic HUM membership by only ~25,000. Each of its ~250 captive clinics cares for ~1,000 members. Given that HUM has ~5.5 million MA members, the number of additional owned clinics it would have to open and staff to cover a meaningful percent of its own members would be in the thousands
- CVS' OakStreet cares for fewer than 200,000 MA members at-risk, of which ~15% (~30,000) are insured by AET/CVS. However, AET/CVS insures ~3.5 million MA beneficiaries, so OakStreet cares for less than 1% of these beneficiaries
- ELV reports that ~20% of its medical expenses flow through its captive provider organizations. Not bad, but nowhere close to fully aligned
- Walgreen's, which has invested heavily in its own integrated clinical care platform through VillageMD, Summit, and CareCentrix, as well as CVS which just spent close to $20 billion for Signify and Oakstreet, have both either revised guidance downward or revoked previously issued out-year guidance. Both companies attribute a good part of these revisions to difficulty integrating their recent healthcare acquisitions

Implications: Reliable growth in the core health insurance business will be increasingly dependent on performance in Medicare Advantage. As CMS elevates the conditions under which this segment can remain profitable, we will likely see both an increase in competitive intensity

and a divergence of performance. Those with superior STARs, RAF, and member retention capabilities will create a virtuous, self-reinforcing upward cycle for themselves. Those who cannot deliver on these dimensions of performance will enter a vicious downward cycle. CNC's $200 million investment in "premium deficit reserves" is an attempt to prevent such a vicious cycle.

Second, the economic surplus created in insurers' PBM businesses has now not only attracted the attention of the FTC and Congress, but competitors as well. Several insurers have become highly dependent on profits from this less-regulated part of the sector, and should begin to evaluate a world where rebates disappear. This likely leads to them charging higher transaction fees, but at least such a change would no longer encourage more use of higher list-priced drugs.

Lastly, the implication of the challenge facing large integrated insurers associated with aligning meaningful percentages (e.g., over 50%) of their Medicare Advantage members with their own captive provider platforms is becoming clear: unless these insurers are willing to spend billions and billions of dollars more, and sustain the operating losses incurred over 3-5 years as these platforms scale, they may need to simply take the write-downs and manage them as standalone provider business units similar to how UNH does it.

Market and Competitive Dynamic #3- New Proposed Federal Government Merger Guidelines (better described as "Anti-Merger" Guidelines)

On July 19th, the DOJ/FTC issued new proposed Merger Guidelines. While these are not yet final, their explicit and implicit assumptions are alarming and reveal no small amount of naivete regarding dynamics in the healthcare sector. The overall thrust of the guidelines is that the FTC would much prefer "organic growth and efficiency gains" to M&A as sources of value creation. The proposal comprises 12 separate guidelines. Among these 12, the FTC seems to be obsessed with

ensuring markets are competitive, which they define essentially as lack of M&A-induced market share concentration. Many regulatory economists favor markets that are contestable (meaning accommodating to new entrants regardless of market share concentration). It is also curious that the FTC is not as worried about overall market concentration as long as it's *not* achieved through M&A. In the end, what is the difference? Many of the FTC's assertions seem to be at odds with the reality on the ground in the healthcare sector:

- More concentration of high complexity case volumes such as organ transplants has proven to dramatically improve outcomes. Doesn't that matter?
- The Guidelines suggest the FTC may favor an acquisition of an "imminently failing institution" to preserve competition, but why would the prospective buyer invest in such an economic sinkhole if that buyer would benefit from its "imminent" closure anyway?
- If more distributed market share and ease of entry are vital to protect the healthcare consumer, why doesn't the FTC challenge State-imposed Certificate of Need (CON) laws?
- The FTC claims that more concentration and fewer players can lead to increased "coordination" rather than competition among them. My observation has been the opposite in healthcare. Think Pittsburgh, Houston, and Palm Springs for instance
- CMS issues models and guidance encouraging health systems to assume more risk for Medicare beneficiaries and this requires a significant regional presence and a big balance sheet; which often cannot be achieved without a significant amount of market concentration
- One merger consideration supported by the Supreme Court over the FTC's previous deliberations relates to whether the benefits of scale economies derived from a merger, and passed on to the consumer, exceed the potential risk associated with increased concentration. This may be an opening if it can be proven

Implications: If the current DOJ/FTC leadership remains in place beyond the current election cycle, M&A approvals will become increasingly complicated, drawn out, and expensive. If there is any cause for optimism, it is that the FTC seems to be losing court decisions challenging their premises. Given the massive potential investments in emerging technologies such as various forms of artificial intelligence applications, consumer solutions, new venues of care, and value-based care capabilities, scale will become increasingly important.
Those seeking the benefit of scale in the absence of M&A may now need to get more creative about joint ventures, joint investment vehicles, and cooperative agreements

Some Interesting Factoids

Here are some interesting paraphrased excerpts from this quarter's earnings calls:

"So, I would say very strong demand for mental health that continues to be top of mind among health plans, employers, consumers" (Teledoc)

"We expect about 65% of our growth in Medicaid membership experienced during the pandemic to roll off during redeterminations" (Centene)

"For select patients, acute care at home is safe, improves patient satisfaction, and provides high-value care, resulting in approximately a 20% reduction in cost, a 25% reduction in readmissions, and a 50% reduction in time spent in bed" (Elevance)

“In areas such as cancer or cardiovascular disease, we see no evidence (of severe disease progression due to deferred care), while monitoring it closely” (United Healthcare)

“We have also developed an enhanced version of our Spanish-speaking features to better serve the 30% of our (ACA) membership base who are Spanish speaking” (Oscar)

“On profit progression, what we typically said is that it takes about 3 years for either an age-in or another new MA member to reach mature contribution margin” (Humana)

“Now we have physician cost pressures with respect to professional fees. And our belief is that this will have to be paid by someone” (HCA)

“We are experiencing a slower profit ramp for U.S. Healthcare” (Walgreens)

“A recovering healthcare ecosystem looking for lower cost sites of care and ongoing innovation in ambulatory surgery care delivery. These factors collectively create a foundation for continued growth (in ASC activity)” (Tenet)

Ok, that’s it for this quarter. I hope you find these observations useful.